Part 6: Objective Based Allocation (OBA)

Sections 6.1 – 6.7

Section 6.1: OBA Overview and Development

In 2007, DDRS and an external group of stakeholders consisting of advocates, providers, and industry professionals began the research and development of an objective based allocation method.

Development strategy included baseline research, provider cost reporting, modeling, assessment validation, pilots, and best practices. Modeling was used to determine the parameters for Algorithm development (Algos)

The Objective Based Allocation (OBA) is the method used by the state to determine the level of supports an individual needs in order to live in a community setting. The OBA is determined by combining the Overall Algo (determined by the ICAP and ICAP addendum), Age, Employment, and Living Arrangement. For more information on the OBA please refer to training modules that were offered as guidance on the implementation of this new method.

Section 6.2: ICAP Assessment and Algo Level Development

The nationally recognized Inventory for Client and Agency Planning (ICAP) was selected to be the primary tool for individual assessment.

The ICAP assessment determines an individual's level of functioning for Broad Independence and General Maladaptive Factors. The ICAP Addendum, commonly referred to as the Behavior and Health Factors, determines an individual's level of functioning on behavior and health factors.

These two assessments determine an individual's overall Algo level which can range from 0-6. Algos 0 & 6 are considered to be the outliers representing those who are the highest on both ends of the functioning spectrum.

The Objective Based Allocation (OBA) is determined by combining the Overall Algo (determined by the ICAP and ICAP addendum), Age, Employment, and Living Arrangement

The stakeholder group designed a building block grid to build the allocations. The building block grid was developed with the following tenets playing key roles: Focus on Daytime Programming; Employment; Community Integration; and Housemates.

After the assessments are completed and the information is received by the State, the participants and their support teams are required to review the information and ensure that it accurately reflects them. Upon completion the participant will be notified of the allocation limit through their case manager.

Individual teams may request a formal review of their allocation through their case manager. Teams are

asked to review the ICAP and ICAP addendum and provide supporting documentation to substantiate an
individual's need for placement in a different Algorithm level. The supporting documentation is reviewed as well as the Person Centered Planning Document, Individualized Service Plans, Behavior Support Plans, High Risk Plans and any other collateral documentation needed to analyze the individual's Algorithm level.

Section 6.3: Budget Review Questionnaire (BRQ) and Budget Modification Review (BMR)

"Budget Review Questionnaire" means a set of qualifying questions to determine why a budget review is necessary. The Budget Review Questionnaire is submitted by the individual's case manager based on information provided by the Individualized Support Team.

Adjustments to the allocation limit may also occur when the participant has a change in their needs. Individual support teams may request a review of the assigned allocation limit through their case
manager via a Budget Review Questionnaire (BRQ). The individual support teams must first review the functional assessment findings and provide any other supporting documentation that might lead to an adjustment in the allocation limit. When requested, reviews are conducted by a personal allocation review team within DDRS. If appropriate, adjustments and/or recommendations are provided by the DDRS review team. In addition, a Budget Modification Review (BMR) allows the participant to request short term increases in funding beyond the allocation limit if specific conditions apply. These conditions consist of a change in medical or behavioral needs or a change in living arrangement.
The BMR provides the participant the ability to request additional funding for a short amount of time to
meet their needs that are outside the original allocation limit funding amount.

An individual or their legal representative may appeal the ICAP assessment if they feel it is inaccurate. The consumer/legal guardian has the right to appeal any waiver-related decision of the state within 30 days of Notice of Action (NOA). A Notice of Action (NOA) is issued with the release of each State decision pertaining to a Plan of Care/Cost Comparison Budget (CCB). Each NOA contains the appeal rights of the consumer as well as instructions for filing an appeal.

The BMR process is in place for waiver consumers who experience circumstances where additional funds are needed for short-term, unanticipated situations. Each initial event requested, if approved, shall not exceed ninety (90) days.

In order for a BMR to be considered, the following must first be sought:

- Housemates

- Electronic Monitoring Service
- Medicaid Prior Authorization Services
- Natural Supports

The individual's Case Manager (CM) is responsible for submitting initial BMR.

BDDS will respond to a new BMR within seven (7) business days of submission.

- final decision on BMR will not be made until CM responds to all inquiries from BDDS.

BUDGET MODIFICATION REQUEST CATEGORIES (FOR CONSIDERATION)

- Loss of a housemate due to:
    - death;
    - extended hospitalization of fourteen (14) or more days;
    - nursing facility respite stay of fourteen (14) or more days;
    - incarceration of fourteen (14) or more days;
    - State substantiated abuse, neglect, or exploitation;
    - State intervention for behavioral needs;
    - State intervention for health or medical needs; or
    - housemate changes Providers.

- Loss of employment.

- State substantiated abuse, neglect, or exploitation.

- Behavioral needs requiring State intervention.

- Health or medical needs requiring State intervention.

DOCUMENTATION REQUIREMENTS

Documentation requirements for Budget Modification Requests include, but are not limited to the following:

- If increased behaviors result in a BMR, documentation regarding changes to the consumer's behavior plan, staff trainings, etc. will be required within 30 days of the request for the BMR to be considered.
    - If behaviors are anticipated to last longer than ninety (90) days, a Budget Review Questionnaire should be completed rather than a BMR.

- In order for a BMR to be considered in Crisis situations a consumer must first go through the Crisis process.

- Individualized Support Teams (ISTs) must work together to address the individual's need and develop a long term plan within the individual's resources.

    - ISTs will be asked to submit these long term plans and objectives for all additional Budget Modification Requests.

Section 6.4: Assessment (Algo) Level Descriptors

Level	Descriptor
0 Low	High level of independence (Few Supports needed). No significant behavioral issues. Requires minimal Residential Habilitation Services.
1 Basic	Moderately high level of independence (Limited supports needed). Behavioral needs, if any, can be met with medication or informal direction by caregivers (through the use of Medicaid state plan services). Although there is likely a need for day programming and light Residential Habilitation Services to assist with certain tasks, the client can be unsupervised for much of the day and night.
2 Regular	Moderate level of independence (Frequent supports needed). Behavioral needs, if any, met through medication and/or light therapy (every one to two weeks). Does not require 24-hour supervision – generally able to sleep unsupervised – but needs structure and routine throughout the day.
3 Moderate	Requires full-time supervision (24/7 staff availability) for medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting
4 High	Requires full-time supervision (24/7 frequent and regular staff interaction, require line of sight) for medical and/or behavioral needs. Needs are moderately intense, but can still generally be provided in a shared setting.
5 Intensive	Requires full-time supervision (24/7 absolute line of sight support). Needs are intense and require the full attention of a caregiver (1:1 staff to individual ratio). Typically, this level of services is generally only needed by those with intense behaviors (not medical needs alone).
6 High Intensive	Requires full-time supervision (24/7 more than 1:1). Needs are exceptional and for at least part of each day require more than one caregiver exclusively devoted to the client. There is imminent risk of individual harming self and/or others without vigilant supervision.

Section 6.5: OBA Service Hours

	ALGO Level						
Individual RHS Daily Hours	**0**	**1**	**2**	**3**	**4**	**5**	6
	Low	**Basic**	**Regular**	**Moderate**	**High**	**Intensive**	**Intensive & High Intensive**
Living with Family	0.2	2	3	4	5	6	6
Living Alone	0.2	2.6	6	9	11.7	21	21
Living with One Housemate	0.2	2.6	5.3	7.8	11	12	12
Living with Two Housemates	0.2	2.6	4.6	7.8	10.1	11	11
Living with Three Housemates	0.2	2.4	4.3	7.3	9.4	10	10
BMAN Reserve (Annual hrs)	0	0	36	72	108	144	144
Day Service Reserve ($/Yr)							
Not Attending School	$ 10,500.00	$ 10,500.00	$ 10,500.00	$ 10,500.00	$ 10,500.00	$ 18,000.00	$ 18,000.00
Attending School or under 19yrs.	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00

Section 6.6: Implementation of Objective Based Allocations

Individuals will receive their new OBA on their annual renewal date. The first group will be the January 1st population. Over the course of 12 months, all waiver participants will be transitioned to an OBA when their waiver is up for annual renewal.

Allocations will receive a pre-release review focusing on individuals whose allocations drop or increase significantly from their previous cost comparison budget.

Training on the OBA can be found on FSSA website at http://www.in.gov/fssa/ddrs/4194.htm

Section 6.7: PAR Review and The Appeal Process

An individual support team may request a PAR (Personal Allocation Review) through the Case Manager via BRQ (Budget Review Questionnaire). The BRQ states the reason for allocation review; i.e. Algo level is incorrect; ICAP assessment has significant error; ICAP Addendum (Behavior and Health Factors) are incorrect; living arrangement is incorrect; etc. The BRQ is submitted to the district BDDS office for review and then submitted to the PARS unit for a PAR review.

If an individual has not received their BRQ results back prior to the new plan start date, the case manager may request a BMR monthly until the BRQ results are completed by the PAR unit.

The PAR reviewer will notify the case manager of any change in Algo or allocation based on their review.

If the individual support team is unhappy with the PAR review, or wishes to appeal without a PAR review, they may appeal one or more of the OBA components after their NOA (Notice of Action) has been generated: The ICAP Assessment; ICAP Addendum (Behavior and Health Factors) are incorrect; or Living Arrangement.

To generate a NOA, a CCB must be submitted at the allocation level or the IST cannot submit a CCB and a default CCB will generate the NOA.

To continue services at the previous year's service level, the team must request a BMR using the "oba xfer" category as the qualifier.

The appeal process, which has not changed with the OBA, is located on the back pages of the NOA and is stated below:

The Right to Appeal and Have a Fair Hearing:

If your application or service is denied, you may file an appeal within 30 days of the decision date shown on this notice. The time limit for filing an appeal is extended by three (3) days if this notice is received by mail. Your Home and Community Based Services (HCBS) benefits will continue if you file an appeal within the required time frame of the decision notice. If you appeal and your benefits are continued and you lose the appeal, you may be required to repay assistance paid in your behalf pending the release of the appeal hearing.

How to Request an Appeal:

- If you wish to appeal this decision, you may request an appeal within 30 days of the date of this notice. The time limit for filing an appeal is extended by three (3) days if this notice is received by mail. To file an appeal, please sign, date and return the Hearings & Appeals copy of this form to:

  Office of Hearings and Appeals
  MS 04
  402 W. Washington St. Room E-034
  Indianapolis, IN 46204

  - If you are unable to sign, date, and return this form to the above mentioned address, you may have someone assist you in requesting the appeal.

- You will be notified in writing by the Indiana Family and Social Services Administration, Hearings and Appeals office of the date, time, and location for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the Case Manager.

- You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative or other spokesperson. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances advance any arguments with interference and question, or refute any testimony or evidence presented.